HMO GROUP CHECKLIST

(Health Benefit Plan)

This checklist applies to health maintenance organizations. This checklist does not apply to Medicare Supplements. It does not apply to any other type of organization.

( ) Review with Basic Insurance Policy Checklist – 806 KAR 14:007.
( ) Review with checklist for Internal Appeals/External Reviews.

( ) 806 KAR 38:030 Does the contract have a form number?

( ) KRS 304.38-050 Do the contract and certificate contain:
(1) a clear statement of the services to which the enrollee is entitled?
(2) a clear statement of any limitations on services, kinds of services or benefits, including deductibles and co-payments?
(3) a clear statement telling the enrollee where and in what manner information is available as to how services may be obtained?

Mandatory Provisions (policy and certificate)

( ) KRS 304.18-110(4) Continuation. Persons covered under state continuation under the replaced plan remain under the replaced plan.
( ) KRS 304.38-191
( ) KRS 304.18-114 Conversion; terms of conversion, notice.
( ) 806 KAR 17:260

( ) KRS 304.38-1935 Does contract provide for low-dose mammography screening?
( ) KRS 304.17-316

( ) KRS 304.17-316(2) (b) Requires coverage for mammograms, regardless of age, for a covered person diagnosed with breast disease.

( ) KRS 304.38-1937 Does contract provide for TMJ?

( ) KRS 304.38-195 Is coverage of services performed by a dentist covered when performed by a physician?

( ) KRS 304.38-196 Is indemnity payable for services performed by chiropractors, physicians, and osteopaths?

( ) KRS 304.17A-275 Osteopathy coverage must be provided.

( ) KRS 304.38-1955 Services performed by an optometrist or ophthalmic dispenser to include the same services performed by a licensed physician.

( ) KRS 304.17A-146 Coverage must be provided for registered nurse first assistant if assistance is covered and the nurse is qualified to assist.

( )	KRS 304.17A-138	Requires coverage for telehealth services
( )	KRS 304.38-1933	Coverage for licensed psychologist or licensed clinical social worker
( )	KRS 304.17A-171	(With the exception of subsection 1, the other provisions within 171 may not necessarily be in the contract.) (1) referrals cannot be required for chiropractic services (2) allows chiropractors to coordinate care provided the care is within the scope of their license (3) cannot discriminate between individual providers in the amount of compensation or reimbursement (4) cannot promote or recommend an individual provider
( )	KRS 304.38-199	Are newborn children covered from birth? Does contract require payment of a premium fee for addition of newborn? If so, it may require notification of birth within thirty-one (31) days and payment of fee for continuation.
( )	KRS 304.17A-140	Coverage required to be provided for legally appointed guardian or legally adopted child.
( )	KRS 304.17A-139	Requires coverage for necessary care and treatment of medically diagnosed inherited metabolic diseases for newborns. Coverage for amino acid modified preparations & low–protein modified food for inherited metabolic disease for conditions listed in KRS 205.560(1)(c), if prescription drugs are covered. Benefits can be limited to $25,000 per year for medical formulas & $4,000 per year for low-protein modified foods.
( )	KRS 304.17A-135	Autologous bone marrow transplantation (ABMT) for breast cancer
( )	KRS 304.17A-145	Hospital stay for maternity coverage requirement
( )	KRS 304.17A-1473	Coverage must be provided for services of a physician assistant if coverage is provided for surgical first assisting or intraoperative surgical care benefits or services.
( )	KRS 304.17A-250(9)	Also refer to 806 KAR 18:030 on how to apply COB. Health Benefit Plan must coordinate benefits. Must use benefit reserve.
( )	KRS 304.17A-250(8)	Hospice coverage must be provided at least equal to Medicare benefits (exempt for HSAs)

( ) KRS 304.17A-250(14) No individual shall be required to replace an individual policy with group coverage when becoming eligible for group coverage that is not provided by an employer

( ) KRS 304.17A-240(4) Coverage can be modified at renewal, upon prior approval

( ) KRS 304.17A-220(4)(a)&(b) Define prior creditable coverage if pre-existing condition exclusion is used

( ) KRS 304.17A-220(3)(a) If pre-existing condition exclusion is used the following cannot be considered as a preexisting condition:
(a) genetic testing information,
( ) KRS 304.17A-155 (b) domestic violence
( ) KRS 304.17A-220(5)(c) (c) pregnancy cannot be considered a pre-existing condition.(**It can be considered in individual plans)**
( ) KRS 304.17A-220(5)(a) (d) newborn/adopted/guardianship children should not have a pre-existing condition exclusion if coverage is applied for within 31 days from eligibility.
( ) KRS 304.17A-220(2)(a) (e) pre-existing condition definition with the six-month lookback provision
( ) KRS 304.17A-220(2)(b) (f) pre-existing condition no longer than 12 months
(g) pre-existing no longer than 18 months for late enrollees

( ) KRS 304.17A-220(4)(a)&(d) Credit for prior coverage provided there is not more than a 63-day lapse in coverage

( ) KRS 304.17A-220(7)(b)2 Special enrollment period provision.

( ) KRS 304.17A-220(3)(c) Late enrollee provision

( ) KRS 304.17A-220(3)(b) Enrollment date is the first day of coverage. (If there is a waiting period it does not constitute break in coverage)

( ) KRS 304.17A-200 Guarantee issue for small group (Large group, small group or association group cannot use the criteria in subsection (1)(a) through (h) as a basis for eligibility for individuals in the group)

( ) KRS 304.17A-240(2) Guarantee renewal of health benefit plans except for:
(a) Failure to pay premiums or contributions;
(b) Fraud or intentional misrepresentation of material fact;
(c) Intentional and abusive noncompliance with material provisions of plan;
(d) Insurer ceasing to offer coverage in the individual or group market;
(e) For individual network plans, individual no longer resides, lives or works in service area, for group network plans there is no longer any employee who resides, lives or works in the service area;

(f) Membership of individual or employer in a bona fide association ceases;
(g) Group no longer meets participation requirements or contribution requirements established by insurer.

( ) KRS 304.17A-505 Disclosure of covered services, restrictions or limitations, financial responsibility of covered person, prior authorization requirements with respect to covered services, where and how services may be obtained, changes in covered services, covered persons right to an internal appeal and procedures to initiate internal appeal, and covered persons right to external review and procedures to initiate external review, and measures to ensure confidentiality of the relationship between an enrollee and a health care provider.

( ) KRS 304.17A-535(4) Insurers must have an exception policy for plans that restrict pharmacy benefits to a drug formulary. (Applicable to closed formulary)

( ) KRS 304.17A-505(j) Must include a statement that a complete formulary is available upon request.

( ) KRS 304.17A-245 <u>Cancellation requirements</u>:
(1) Requires 30 days' advance written notice of cancellation;
(2) Cancellation for non payment of premium effective to last day thru which premium was paid;
(3) Provide notice of right to conversion within 15 days following end of grace period for each group member;
(4) Automatic termination provision for non payment of premium;
(5) Return of unearned portion of premium paid;
(6) The coverage continues if 30 days' notice is not provided;
(7) Must include reinstatement policy in event of cancellation due to non payment of premium. Reinstatement may not be denied on any health-related factor listed in KRS 304.17A-200 or on consideration of medical loss ratio.

( ) KRS 304.17A-240(3) Notice of Cancellation
(a) 90-days prior notice and offer of other coverage when a type of plan is discontinued
(b) 180 days' notice and 5-year ban from new sales when all plans are discontinued and not renewed

( ) KRS 304.17A-510(1)(d) A statement regarding the effect on the enrollee of any hold harmless agreement must be included in the policy. Description of and limitation to enrollee liability.

( ) KRS 304.17A-500(4) Definition of emergency medical condition cannot conflict with or be more restrictive than this section allows.

( )	KRS 304.17A-580(2)	Emergency room care prudent layperson rule and must be based on presenting symptoms.
( )	KRS 304.17A-643(2)	Special circumstances when the insured can have continued care with a same provider even though the provider is no longer participating. Treating provider must make the request with concurrence with the covered person. (Must inform insureds of when they can have continuity of care)
( )	KRS 304.17A-647(2)	A female may be covered for an annual pap smear performed by an obstetrician or gynecologist without a referral from a PCP.
( )	KRS 304.17A-515(1)	(Plan rules) Adequate choice of providers. Must allow enrollees to choose their own providers from the list. Enrollees must be allowed to use specialists when their condition warrants it. The plan must arrange continuity of care and appropriate referral to specialists. The plan must allow women to choose a qualified provider offered by the plan to provide routine and preventive women's health care services.
( )	KRS 304.17A-520	Managed care plan shall provide access to a consultation with a participating provider for a second opinion.
( )	KRS 304.17A-540	Coverage limits for treatments, procedures, drugs or devices to be defined and disclosed in the policy or certificate; denial letter requirements.
( )	KRS 304.17A-550	Managed care plans must offer a benefit plan with out-of-network benefits, no referral required.
( )	KRS 304.17A-131	Cochlear implants coverage
( )	KRS 304.17A-132	Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.
( )	KRS 304.17A-143	Autism coverage
( )	KRS 304.17A-148	Diabetes coverage
( )	HIPAA	Mental Health Parity (Cannot put limits on mental health coverage in large groups) (Mental health offering if elected is more comprehensive than HIPAA)
( )	KRS 304.17A-661(1)	Large group mental health coverage must be provided on the same basis as physical health coverage if mental health coverage is provided.

( )	KRS 304.17A-149	Requires coverage for payment of anesthesia and hospital or facility charges in connection with dental procedures for; children below the age of nine; persons with serious mental or physical conditions; & persons with significant behavioral problems, in all health benefit plans that provide coverage for general anesthesia and hospitalization services.
( )	KRS 304.17A-243	Must include a grace period provision.

Required Options

( )	KRS 304.38-193	Can master policyholder purchase coverage for mental illness?
( )	KRS 304.38-197	Can master policyholder purchase limited coverage for alcoholism? (N/A if the contract meets or exceeds the coverage in the contract)
( )	KRS 304.38-198	If maternity benefits are provided, may the master policyholder purchase coverage of up to five (5) days nursery care for a well-born child? (N/A if routine nursery care is covered in the contract)
( )	KRS 304.38-210	May the master policyholder purchase home health care benefits? (N/A if the contract covers 60 or more home health visits in the contract) Must be subject to same deductible and coinsurance as other covered services. Must not be reimbursed without physician's certification. Must pay Medicare beneficiary for services not paid for by Medicare and not exceeding the maximum liability of the Policy.
( )	KRS 304.17A-134 & KRS 304.38-1934	Breast reconstruction, treatment of endometriosis and endometrisis, and bone density testing. Mastectomy coverage cannot be required on an outpatient basis.
( )	Labor Law	Maternity coverage for employer groups with 8 or more employees

Other Requirements That Do Not Have To Be In Policy

( )	KRS 304.17A-535	(May not be in the contract) A managed care plan must include a drug utilization review program with emphasis on quality of care by assuring appropriate drug therapy.
( )	KRS 304.17A-607 (1) (h) & (i)	Timeframes for UR decisions.

( ) KRS 304.17A-590 (1) No longer requires provider directories to be provided unless requested.

( ) KRS 304.17A-641 (1) An insurer that requires prior authorization for poststablization treatment in an emergency care situation at a nonparticipating hospital, approval or denial shall be provided in a timely manner, but in no case to exceed two hours from the time request has been made and all relevant information provided. Failure to provide timely approval shall constitute approval.

( ) KRS 304.17A-645 A PCP treating a person with a chronic, disabling, congenital, or life threatening condition may authorize a referral to a participating non PCP specialist, up to 12 months or for the contract period, whichever is shorter.

( ) KRS 304.17A-647 Insurers cannot prohibit a PCP from referring a covered person who is pregnant or has a chronic gynecological condition to authorize a referral to a participating obstetrician or gynecologist for up to 12 months or for the contract period, whichever is shorter.

( ) KRS 304.17A-515 Managed care plans must have a sufficient number of providers including primary and specialist physicians and must provide adequate information regarding access to emergency and urgent care services. Reasonable waiting times and telephone access.

( ) KRS 304.17A-250(7) Benefit comparison provided to prospective applicant, who signs statement of receipt. Applies to non-employer groups (associations), small group and individual only.

( ) KRS 304.17A-505 Disclosure of information regarding premium, benefits and pre-existing conditions in solicitation materials. (For small groups)

( ) KRS 304.17A-525 Managed care plans must establish standards for initial consideration of providers and for providers to continue as participating providers. Must establish mechanisms for soliciting and acting upon provider applications. When a primary care provider is terminated, the plan must give notice to the enrollee and arrange for continuity of care with a primary care physician. The plan must have a plan for removal of providers.

( ) KRS 304.17A-530 Managed care plans cannot limit or penalize or terminate providers because they discuss medically necessary care with an enrollee or discuss financial incentives or financial arrangements between the provider and the plan. Upon the request, the plan must provide information to the enrollees

about the type of financial arrangements between the plan and their providers.

( ) KRS 304.17A-702 Payment of claims requirements

( ) KRS 304.17A-545 A managed care must appoint a medical director who is a licensed physician. The director is responsible for treatment policies, protocols, quality assurance activities, and utilization management decisions.

( ) KRS 304.17A-555 Patients' right of privacy

( ) KRS 304.17A-230(2) Certification of prior coverage

( ) KRS 14-230 SB 153 The policy may be delivered by electronic transfer, by agreement between the insurer and the insured or the person entitled to receive the policy.

Group statutes that also apply to group HMO coverage (KRS 304.38-200)(15)

( ) KRS 304.18-035 Ambulatory surgical centers

( ) KRS 304.18-030(1) Representations-not warranties

( ) KRS 304.18-030(2) Summary of benefits provided

( ) KRS 304.18-030(3) Additional new enrollees allowed

( ) KRS 304.18-126 Policies to provide reasonable Extension of Benefits (HMO 12 mo.)

( ) KRS 304.18-127 Liability of succeeding insurers.

Prohibited Provisions

( ) KRS 304.12-013 Coverage for AIDS cannot be excluded.

( ) KRS 304.17A-220(4)(b) No pre-existing can be used if an affiliation period is used.

( ) KRS 304.14-370
( ) KRS 304.14-380 Binding arbitration cannot be required. Arbitration can be an option for the insured.

( ) KRS 304.5-160 Health insurance contracts cannot cover abortion except by rider.

( ) KRS 304.17A-150 (1) Anyone marketing insurance cannot encourage anyone not to file an application for health insurance based on health condition.
(2) Encourage anyone to apply for insurance with another carrier because of health status.
(3) Encourage an employer to exclude an employee from

coverage.

(4) Insurers are prohibited from compensating any person marketing insurance on the basis of health status, claims experience, industry, occupation or location of the perspective insured.

(5) Insurers must compute the insured's coinsurance or cost sharing amount on the basis of the actual amount received by a health care provider from the insurer.

Service Area

HMOs should specify contiguous counties and identify restricted providers within an approximate 30-mile/30-minute radius. KRS 304.17A-515(1)(e)2. allows a 50-mile/50-minutes rule for rural areas.

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